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Standards for Local Public Health Services: Where Stand the States?

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Abstract: Of the 47 states that participated in a 1983 survey of State Health Departments, 30 were found to have public health standards in place or started. Most states' standards emphasize the range of services to be provided, but substantial variations were found in how standards are formulated, adopted, and used by state and local agencies. (*Am J Public Health* 1985; 75:649–650.)

Introduction

Although a few state health departments established standards for local public health practice some decades ago, recent rapid developments have been linked to the enactment of the Stafford Amendment to the Health Services Extension Act (P.L. 95-83, Sec. 314) early in 1977. The Department of Health, Education, and Welfare, instructed by Congress to develop "model standards" for preventive health services, enlisted the national-level collaboration of the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACHO), the US Conference of City Health Officers (USCCHO), and the American Public Health Association (APHA). This process and its product[1] helped to initiate or accelerate indigenous efforts in many states and localities. Those efforts were likely influenced, as well, by changes in public health funding, including the federal block grants.

Methods

The Health Administration Section of APHA, to assess the "state of practice" and facilitate information exchange, carried out a survey at the end of 1983 through an open-ended questionnaire to state health officers. Salient features of the survey were:

- The use of each state, including its localities, as the unit of analysis (thus excluding the District of Columbia and the US Territories).
- Collection of descriptive and perceptional data on the status of each state's standards and the processes by which they were formulated, installed, and are used in public health management.,
- In view of ambiguities of definition found in a 1977 baseline survey,[2] the provision of a common definition of standards as: norms meant to influence public health programs and services on a community-wide basis, distinguishing such norms from those of categorical federal programs and those of statutes, codes, and regulations affecting the actions of the public, producers, and marketers.

All but three states responded to the canvas, and a report of the survey,[3] published by APHA, contains state-by-state descriptions and directory information. This report summarizes information obtained on the main subjects of the survey.

Results

The *development status* of the states is shown in Table 1. Data on states where all or most public health services are delivered by the state health agency are distinguished from those of states where local health departments have some degree of autonomy, because standards implementation in these two groups involves different relationships, constraints, and processes.

Of the 30 states with systems of standards in place or started, all but five either initiated their systems since 1977 or have made substantial changes since then; seven of these states were involved in major system revisions at the end of 1983.

The predominant types of *criteria and indicators* used in standards (Table 2) pertain to processes (range, quantity and quality of services; management provisions and procedures) and to inputs (personnel norms prescribed in the standards of 14 states). Nine states reported using health outcome indicators in some of their standards.

Two-thirds of the states used ad hoc, special, or standing committees made up of state and local agency representatives to *formulate and revise* standards (Table 3). State health department staffs formulate standards in 11 states (four of them with state-provided local services); at the other extreme, standards were formulated in two states by committees of local officers, and the state then provided legal authorization.

TABLE 1—Status of Standards of 50 States, 1983

Status	State-Provided Services	Other	Total
Systems in place or started	5	25	30
(states involved in major revisions)		(7)	(7)
Systems being developed		7	7
No development activity	5	5	10
Not reported			3
Total	10	37	50

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TABLE 2—Criteria and Indicators Used in Standards (N = 26)*

Type of Criteria	Number	Per Cent
Range of programs and services to be provided	21	81
Quantity/quality of services	19	73
Personnel qualifications	14	54
Management processes	14	54
Health outcomes	9	35

*Four of 30 states with established systems were in the process of negotiating criteria.

TABLE 3—Primary Agents in Formulating Standards (N = 33)*

Agents	Number	Per Cent
Committees of local administrators	2	6
State-local standing committees	8	24
State-local ad hoc or special committees	15	45
State health department staff	11**	33

*Includes 30 states with established systems and three states then developing systems.
**Of these, two also used state-local ad hoc committees and one also uses a state-local standing committee.

TABLE 4—Means of Formal Adoption (N = 27)*

Mode of Adoption	Number	Per Cent
Legislation	4	15
Formal administrative rule-making	10	37
State Board of Health approval	6	22
State Health Officer approval	12	44
Total	32**	

*Information not available from three of 30 states with established systems.
**One state used all four modes; two others used two modes each.

In about half of the states, the *formal adoption* of standards (Table 4) was effected under the authority of the State Health Officer or Board of Health. In the others, "outside" authority comes into play, through formal rule-making procedures or legislative approval.

More than half of 28 responding states used standards in three types of *management processes* (Table 5): state-level planning, evaluation and budgeting; local-level planning, evaluation and budgeting; and decisions on allocating state funds (but only six states required compliance with standards to qualify for state financial aid). The use of standards in state evaluations of local programs was found less frequently. However, a number of states reported their intention to employ standards for one or another of these management functions when their standards were more fully developed and when more substantial state financial aid could be provided to local units.

TABLE 5—Uses of Standards in Management Processes (N = 28)*

Management Uses	Number	Per Cent
State planning, evaluation, and budgeting	18	64
Local planning, evaluation, and budgeting	16	57
Decisions on fund allocations	15**	54
State evaluation/auditing of local performance	12	43

*Information was not available on two of 30 states with established systems.
**Six states required compliance with standards as a condition for receiving state financial aid.

Discussion

The most apparent characteristic of the states' standards development at the end of 1983 was the diversity in their progress, processes, and uses of standards. Because the questions put to state rapporteurs were open-ended, the amount of explanatory information received proved insufficient to support a comprehensive analysis. In addition, a number of inadvertent shortcomings in the survey became apparent in the course of analysis. Additional information would have been useful on:

- State-local constitutional and political relationships; the administrative relationships of state and local health departments.
- Patterns and amounts of intergovernmental funding for health, particularly the share of expenditures originating from local revenue sources.
- Specifics of the health outcome indicators used in a few of the standards.
- Explicit reasons why a state was not active in the development and implementation of standards.
- Measurement of the ways in which the "model standards" had affected developments in states and localities.

REFERENCES

1. Model Standards for Community Preventive Health Services. Washington, DC: Department of Health, Education and Welfare, 1979.
2. Bergheim ML: State Standards for Public Health Services: Final Report. Washington, DC: Georgetown University Health Policy Center, 1977.
3. Schaefer M (ed): State Systems of Local Health Department Standards, 1983. Report of the American Public Health Association, Health Administration Section. Washington, DC: APHA, 1984.

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THE KNOWS HAVE IT

He who knows not and knows he knows not is a child. *Teach him.*
He who knows and knows not he knows is a fool. *Pity him.*
He who knows not and knows not he knows not is a knave. *Shun him.*
He who knows and knows he knows is a wise man. *Hear him.*

—From *The American Public Health News,* August 1931.